HCFA MEDICARE • MEDICAID Health Care Financing Administration

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HEALTH watch

HCFA Strategic Plan Renews Focus on Beneficiaries

The Health Care Financing Administration (HCFA) recently announced a new Strategic Plan that emphasizes the agency's focus on beneficiaries and commitment to quality, value and service.

The Strategic Plan focuses all levels of the agency's workforce on its mission to assure health-care security for all Americans who rely on the programs HCFA administers.

"This Strategic Plan renews our focus on the needs of beneficiaries in all of our activities, expenditures and policies," said HCFA Administrator Nancy-Ann Min DeParle. "That is the crucial mission that we must fulfill, and it's what we should all keep in mind each day as we serve our beneficiaries and other Americans."

The plan updates the agency's goals and strategies to meet today's health-care environment and to include new statutory responsibilities created by the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997. The document builds on the agency's first-ever strategic plan, which was released in 1994.

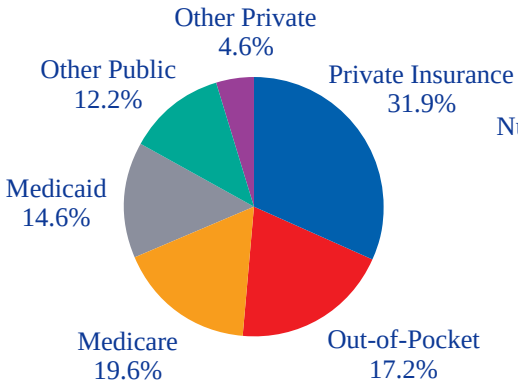
The Strategic Plan's six goals are to protect and improve beneficiary health and satisfaction, promote the fiscal integrity of HCFA programs, purchase the best value health care for beneficiaries, promote beneficiary and public understanding of HCFA and its programs, foster excellence in the design and administration of HCFA's programs, and provide leadership in the broader public interest to improve public health.

The plan includes examples of specific strategies to meet each goal. It supports the Department of Health and Human Services' strategic plan, which was submitted to Congress in 1997 as part of the Government Performance and Results Act. HCFA's success will be measured through performance goals,

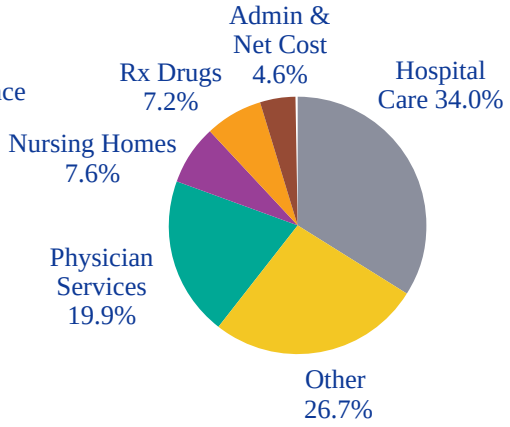
See **Strategic Plan,** page 3

The Nation's Health Dollar: 1997

Where It Came From



Where It Went



Note: Other includes dental services, other professional services, home health, durable medical products, OTC medicines and sundries, public health, research and construction.

Source: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group

Report Indicates Growth in National Health Care Spending As Stable in 1997

Health-care spending in the United States rose only 4.8 percent in 1997, the slowest increase in almost 40 years, according to a new report released recently by the Health Care Financing Administration (HCFA). HCFA reports that health care spending in 1997 totaled $1.1 trillion with per person spending, on average, at just under $4,000.

Long-term estimates by HCFA, however, anticipate that health-care spending will grow more rapidly in the coming years.

The report by HCFA analysts shows that the gap between health spending paid for by public and private sources inched closer in 1997, continuing a trend that began in 1990. Private funding paid for 53.6 percent of health care ($585.3 billion), down from 59.5 percent in 1990, while public programs, including Medicare and Medicaid, paid for 46.4 percent of health care in 1997, up from 40.5 percent in 1990.

The overall slowdown in health spending has been driven largely by rapidly falling growth in private spending, which reached an all-time low growth rate of 2.3 percent in 1994. In addition, since 1994, the rate of spending from public funding sources, primarily Medicare and Medicaid, has slowed, contributing to

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HCFA HEALTH watch

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

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Calendar of Events

Jan. 12-13 — Administrator Nancy-Ann Min DeParle visits the Mayo Clinic in Rochester, Minn.

Jan. 19 — Administrator DeParle speaks at the National Managed Health Care Congress in Washington, D.C., on *Benefitting the Beneficiary.* ◆

Missing Columns

We are not providing *Selected Health Issues on the Web* and *New Regulations/Notices* in this four-page *Health Watch* issue because of space constraints. However, these columns will return in the February issue. ◆

Message from the Administrator

NANCY-ANN MIN DEPARLE

WHENEVER I talk to senior citizens and their families, I'm reminded of how dramatically Medicare changed what it means to grow old in America. Not long after I became HCFA's Administrator last year, a woman at the Marconi Senior Citizens' Club in Philadelphia asked me to bring a message to the President.

"When you see President Clinton, tell him I said thank you for protecting Medicare," she said. "My parents had nothing, but I don't have to worry because I have Medicare."

Because there are millions of Americans like her, we have been fighting hard to protect Medicare and to eliminate the waste, fraud and abuse that robs beneficiaries and taxpayers alike.

The battle involves many fronts and many partners, including our HHS colleague, Inspector General June Gibbs Brown, and her staff; the Justice Department and FBI; state and local authorities; private businesses, doctors and hospitals; beneficiaries themselves; and, of course, the Senators and Representatives who enact the laws governing Medicare.

Medicare's private contractors — the health insurance companies who process and pay nearly a billion claims each year — play an important role. We expect each to investigate patterns of abuse and, when appropriate, to refer suspected cases of fraud to law enforcement.

We've recently taken steps to ensure contractors perform all aspects of their responsibilities effectively, including their efforts to cut fraud and abuse.

For instance, we established a new high-level position to consolidate and manage Medicare's oversight of contractors. A physician who worked with one of our contractors and has experience in Medicare's anti-fraud efforts is filling that position, and existing contractor-management staff will be expanded.

HCFA also will establish a Medicare contractor oversight board to set priorities for contractors that will sharpen the oversight of contractors.

We now require our contractors to use special computer systems to help them identify and investigate suspicious billing patterns. We are requiring them to undergo further training with law enforcement to ensure they properly prepare and refer fraud cases.

This year, we also will hire special fraud-and-abuse contractors using new authority provided by Congress. Once chosen, they will take on specific tasks to protect Medicare's program integrity.

I know that most providers are honest professionals who work hard every day to provide quality care at a reasonable price to our Medicare beneficiaries. I salute them and urge them to join in our fight against waste and fraud.

But we all must do even more. That was the message at the White House in December when I joined President Clinton as he announced legislative proposals that, if enacted, can save Medicare more than $2 billion over five years. The goals of some of those proposals are to:

- Provide new authority for Medicare to hire a wider range of private contractors, and, when needed, to terminate those who perform poorly.
- Ensure Medicare does not pay claims that private insurers should. These and the President's other proposals will give us additional tools to ensure that every dollar Medicare spends is a dollar well spent on quality care.

Together, our efforts will protect and strengthen Medicare, not only for our parents and grandparents but also for our children and grandchildren. ◆

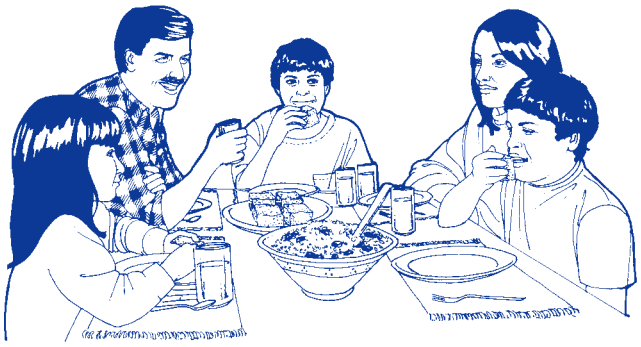
Approved Plans for 44 States, 2 Territories, and the District of Columbia in Force

Wide-ranging Outreach Campaign to Find and Enroll More Eligible Children

The Balanced Budget Act of 1997 authorized the State Children's Health Insurance Program (CHIP). The bipartisan legislation is about children leading healthy lives. It reverses the number of uninsured children by providing insurance to children in working families who either cannot afford private insurance or earn too much to qualify for Medicaid. The five-year, $24 billion CHIP set-aside looms as the "magical booster" to improve children's health by helping their parents afford health insurance for them.

Numbers tell of the insurance needs. On Sept.18,1998, HCFA Administrator Nancy-Ann Min DeParle told the House Commerce Committee Subcommittee on Health and Environment that the number of uninsured children increased from 8.2 million in 1987 to 10.6 million in 1996. These uninsured children make up 16 percent of all children in the United States. And the number of insured children under their parents' employer-based plans dwindled from 67 percent in 1987 to 59 percent in 1995.

For children to qualify for insurance coverage under CHIP, the law gives states broad flexibility in designing a new health insurance program, expanding current Medicaid programs, or combining the two programs to meet their circumstances. State plans are then reviewed and approved by HHS. States with approved-CHIP plans include (in order of approval): Alabama, Colorado, South Carolina, Florida, Ohio, California, Illinois, New York, Michigan, Missouri, New Jersey, Connecticut, Rhode Island, Oklahoma, Pennsylvania, Massachusetts, Wisconsin, Oregon, Texas, Idaho, Puerto Rico, Indiana, Utah, North Carolina, Minnesota, Maryland, Arkansas, Nebraska, Maine, Nevada, South Dakota, Iowa, Kansas, Delaware, Georgia, Montana, New Hampshire, West Virginia, Virgin Islands, District of Columbia, Arizona, North Dakota, Louisiana, Virginia, Mississippi, Kentucky and Alaska. States with proposals under review include Tennessee, New Mexico, Hawaii and Vermont.



Current projections show that an estimated 2.5 million children are expected to be enrolled in CHIP by the end of FY 2000, chipping away at the 10.6 million number of uninsured children counted in 1996. With an outreach campaign in place that began in the summer of 1998, HCFA is partnering with public and private organizations to find and enroll more eligible children in the CHIP and Medicaid programs. Several proposals to help states in this outreach effort are included in the President's FY 1999 budget.

Strategic Plan, from page 1

which are included in the President's budget each year.

HCFA oversees Medicare and Medicaid, which together have met the basic health-care needs of elderly, disabled and low-income Americans for more than 30 years, and administers the new Children's Health Insurance Program, which was created by the Balanced Budget Act to help states provide health coverage to uninsured children. ◆

Funding by State or Territory	Estimated Number of Children	Eligibility (Based on $16,450 annual income for a family of four according to Federal Poverty Level [FPL] guidelines.) All states with CHIP plans will receive federal matching funds only for actual expenditures on insuring children.
Alaska $5.6M	4,900 by October 2000	Alaska will use its federal allotment to expand its Medicaid program to children up to age 19 who are in families with incomes of up to 200 percent of the federal poverty level ($41,140). Eligible children will receive the full Medicaid benefit package. Note: The federal poverty level for Alaska is $20,570 for a family of four.
Kentucky $50M	50,000 by June 2000	Kentucky will use its federal allotment to both expand its Medicaid program and create a separate state CHIP plan. Children ages 14 through 18 who are in families with incomes of up to 100 percent of the FPL ($16,450) will be enrolled in Medicaid. Children from birth through age 18 in families with incomes up to 200 percent of poverty who are not otherwise eligible for Medicaid ($32,900) will be enrolled in a new CHIP insurance plan called K-CHIP. The regular Medicaid benefit package will be offered to new Medicaid enrollees. K-CHIP enrollees will receive a comprehensive benefit package including inpatient and outpatient hospital services, physicians' medical and surgical services, laboratory and X-ray services, and well baby and well child care. Premiums based on the family's income will be charged for the K-CHIP program. Federal law prohibits family costs from exceeding 5 percent of that family's annual income. ◆

Spending, from page 1

lower overall spending growth.

Total Medicaid spending increased only 3.8 percent in 1997, to $159.9 billion, the slowest growth since Medicaid's inception nearly 30 years ago. Preliminary data suggest the slowdown can be attributed to decreases in Medicaid enrollment in 1995, 1996 and 1997, as well as reductions in the rate of spending growth per enrollee.

In 1997, Medicare financed $214.6 billion in health-care spending for its 38.4 million aged and disabled enrollees. However, annual Medicare spending growth slowed from 12.2 percent in 1994 to 7.2 percent in 1997. This reduction reflects, in part, a slowdown in medical price increases, the impact of legislation intended to reduce the growth in Medicare provider payments, changes in provider practices due to fraud and abuse activities, and a small-but-steady decline in the growth of the overall Medicare population.

In 1997, personal health care expenditures reached $969 billion, 89 percent of overall health spending. While spending on hospitals and physicians traditionally accounts for the majority of personal health-care expenditures, the percentage being spent on these services has been declining and offset by increased spending for home health and other health-care services. The largest increase has been in the costs of prescription drugs, which has risen at double-digit rates during the past few years.

Expenditures for hospital care accounted for 38 percent of personal health-care spending and were the slowest growing service, increasing only 2.9 percent to $371 billion in 1997. Spending for physician services increased 4.4 percent in 1997, continuing a trend of single-digit growth started in 1992.

In 1997, expenditures for care provided by freestanding home health agencies reached $32.3 billion. Additional spending provided by hospital-based home health agencies are included with hospital expenditures. Growth in spending for freestanding home health care has slowed from 28.2 percent in 1990 to 3.7 percent in 1997 due, in part, to Medicare fraud and abuse detection activities.

Spending for prescription drugs — $78.9 billion in 1997 — has grown faster than spending for other types of health-care goods and services, increasing 13.2 percent in 1996 and 14.1 percent in 1997. Among the most important reasons for this growth were increases in third-party prescription payments, resulting in lower out-of-pocket spending on prescriptions. In addition, increased consumer demand induced by drug manufacturer advertising, an increase in the number of prescriptions filled and a larger number of new, higher priced drugs entering the marketplace contributed to this rate of growth.

Of the $585.3 billion spent by private sources for health care in 1997, about 60 percent — $348 billion — was paid by private health insurance premiums. The slowdown in premium growth in the 1990s can be attributed, in part, to the move from more expensive fee-for-service health plans into managed care. In 1997, 85 percent of the insured workforce was in some type of managed care plan.

Medicare spending grew 4 percentage points faster than private health insurance (7.2 percent compared with 3.2 percent) in 1997. When examined on a per enrollee basis, Medicare and private health insurance benefits (personal health-care expenditures) have actually grown at comparable average annual rates from 1969 through 1997 (10.4 percent and 11.4 percent, respectively). The average growth in private health insurance per enrollee spending slowed over the period of 1994 to 1996, while growth in Medicare per enrollee spending continued historical trends, creating a gap that concerned policy makers. In 1997, Medicare per enrollee spending grew 5.8 percent, compared with 3.8 percent for private health insurance.

For the first time since the late 1980s, out-of-pocket spending (premiums, coinsurance and copayments) grew faster than private health insurance, reaching $187.6 billion (5.3 percent) in 1997. Some of the accelerated out-of-pocket growth during the last three years may be coming from managed care plans that recently required enrollees to pay more for plan benefits.

While trends in health-care expenditures over the last few years have remained low, HCFA projected earlier this fall that growth in public health spending over the next 10 years will nearly double, reaching $2.1 trillion in 2007. A number of pressures will combine to increase future growth: Insurers experiencing growth in benefit payments higher than premiums earned and the demand by stockholders to correct eroding operating margins will cause premiums to increase. Providers may put added pressure on insurers to raise negotiated payments to offset slower public spending growth due to the Balanced Budget Act of 1997. ◆

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